Marie Ragona, LCAT, ATR-BC
Client Intake Form

Please provide the following information and answer the questions below to the best of your ability and comfort level. Please note: Information you provide here is protected as confidential information.

Name: _____
(Last) (First) (MI)

Birth Date: ____ /____ /____ Age: ___ Gender: _____ Sexual Orientation: _____

Race/Ethnicity:_____

Marital Status:
□ Single □ In a Relationship/Partnered □ Domestic Partnership
□ Married □ Separated □ Divorced □ Widowed

Pronouns: _____

Please list any children/age:
_____ _____
_____ _____

CONTACT INFORMATION

Address:

_____
(Street and Number) (Apt, Suite, etc.)

_____
(City) (State) (Zip)

Cell: _____ May we leave a message? □Yes □No
May we send a text? □Yes □No
*Please note: Texting is not considered to be a confidential medium of communication, so if permission is given, texting will only be used for scheduling, cancellations, or in case of emergency.

Alternate Phone: _____ May we leave a message? □Yes □No

E-mail: _____ May we email you? □Yes □No
*Please note: Email correspondence is not considered to be a confidential medium of communication, so if permission is given, will only be used when necessary.

Referred by: _____

Marie Ragona (917)284-8274
MA, LCAT, ATR-BC Marie@MarieRagona.com

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GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. Have you previously received any type of mental health services?
   □ No □ Yes
   If you are comfortable saying, what was the reason?
   _____
   _____

2. Are you currently taking any prescription or psychiatric medication?
   □ No □ Yes
   Please list:
   _____
   _____

3. How would you rate your current physical health? (please circle)
   Poor Unsatisfactory Satisfactory Good Very good

4. How would you rate your current sleeping habits? (Please circle)
   Poor Unsatisfactory Satisfactory Good Very good

5. How many times per week do you generally exercise? _____
   How would you rate your current exercise habits? (Please circle)
   Poor Unsatisfactory Satisfactory Good Very good

6. Are you currently experiencing overwhelming sadness, grief or depression?
   □ No □ Yes
   If yes, for approximately how long? _____
   Cause(s)?_____
   _____

7. Are you currently experiencing anxiety, panic attacks or have any phobias?
   □ No □ Yes
   If yes, when did you begin experiencing this? _____
   Known Cause(s)?_____

8. How often do you drink alcohol? _____

9. How often do you engage in recreational drug use?
   □ Daily □ Weekly □ Monthly □ Infrequently □ Never

10. Are you currently in a romantic relationship?
    □ No □ Yes. If yes, for how long? _____

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On a scale of (exceptionally negative) 1-10 (exceptionally positive), how would you rate your relationship's impact on your life? _____

11. What are your feelings about sex? What messages did you get about sex from your family/guardians and society growing up?

_____
_____
_____

12. What significant life changes or stressful events have you experienced recently:

_____
_____
_____

13. Do you feel you've been discriminated against due to your gender, ethnicity, race, sexual orientation, religion, nationality/ancestry, or disability? If so, please describe:

_____
_____
_____

FAMILY MENTAL HEALTH HISTORY

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

	Please Circle	List Family Member(s)
Alcohol/Substance Abuse	yes/no	
Anxiety	yes/no	
Depression	yes/no	
Domestic Violence	yes/no	
Suicide Attempts	yes/no	

Other Diagnoses or History you would like us to know about?

_____
_____

ADDITIONAL INFORMATION:

1. Are you currently employed?
   □ No □ Yes
   If yes, name and address of your employer:
   _____
   _____

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Do you enjoy your work? Is there anything stressful about your current work?

_____
_____

2. Do you consider yourself to be spiritual or religious?

□ No □ Yes

If you would like to let us know your faith, religion, beliefs, please feel free to share:

_____
_____
_____

3. What do you consider to be some of your strengths?

_____
_____
_____

4. What do you consider to be some of your challenges?

_____
_____
_____

5. What would you like to accomplish during your time in therapy?

_____
_____
_____

6. Is there anything else you would like your therapist to know?

_____
_____
_____

Thank you for your time and thoughtful responses! Please return this to your therapist at your next session.

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